



Review of the Mental Health Act 2009 (SA)

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Submitted to:

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Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change to improve mental health care across the whole Australian health system. This includes advocating for empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is represented in South Australia by our active South Australian State Advisory Forum and, as such, we are providing a Submission herewith to inform the consultation for the review of the *South Australian Mental Health Act 2009 (SA)*. Our Submission comes from the perspectives and experiences of people with lived experience of mental health issues, their families, and carers.

We welcome the opportunity to provide our response to the South Australian Law Reform Institute in the review of the SA Mental Health Act (MHA). We have detailed our responses to the Consultation Questions which appear at the foot of each of the 10 Fact Sheets.

Impaired decision-making capacity

1. *Should the MHA include a clearer definition of 'impaired decision-making capacity' for treatment orders?*

Given that all restriction imposed under the MHA are based on a person's decision-making capacity, this section is significant. It should be clearly stated so that there are no areas of ambiguity. Also, it must be clear that decisions about capacity should not be seen as total and in all things, i.e., a person may have capacity in some areas but not in others.

A person's right to make decisions in their own best interest is fundamental to their human rights. The potential to take away their rights, which in effect happens under the MHA, means that great care should be taken in the wording of the Act, given its legal basis.

Also, it is important that individuals are given sufficient time to consider options for making decisions. This is captured partially in the current wording of the MHA which states a person will not lack capacity because they can only remember information for a limited time. However, the issue of 'time' is much more significant than this and our experience is that, in practice, information is often provided in a format and at a pace that is rushed, cursory, and not geared to 'walk alongside' the person to given them much chance of grasping it in any meaningful way, leaving them confused and excluded; and potentially judged as not having capacity.

Clear definition is needed because there are significant problems with how the current MHA is operationalised in practice by mental health clinicians and associated agencies such as Police, Ambulance, and the Courts. All too often, when the diagnosis of mental illness is apparent, service providers make assumptions about the person's capacity that may be unduly influenced by inherent stigmatised or discriminatory views. In our own lived experience research with consumers in SA and nationally, we have heard from many people who have been subject to the MHA who have not been listened to, not able to 'reason' with clinicians, even when they have expressed real and rational concerns.¹ This occurs commonly when they seek help for physical health concerns and the issue of 'diagnostic overshadowing' is a well-known problem encountered by mental health consumers.²

¹ Kaine, C. & Lawn, S. (2021) The 'Missing Middle' Lived Experience Perspectives. Lived Experience Australia Ltd: Marden, South Australia, Australia.

² Kaine, C., Lawn, S., Roberts, R., Cobb, L., & Erskine, V. (2022) Review of Physical and Mental Health Care in Australia, Lived Experience Australia Ltd: Marden, South Australia, Australia.

More specifically, the following excerpts from research with SA consumers on CTOs³, exemplifies these concerns about the system cultural context that too often gets despite the human rights principles inherent in the MHA in relation to capacity:

(Jenny, a young woman in her 20s on a CTO) "You have no rights anymore, you can be discriminated against ...They think you're making it up or - like, because obviously you've got a mental illness so everything you say is completely invalidated and discredited... [Of the CTO hearing] ...the lady who conducted the hearing commented, she thought that I was articulate and intelligent, but it didn't really help me very much."

(Jenny)[Of the study interviewer] You respect my autonomy and my right to decide for myself, you know; who I want in my home...and then when you have people, like, police and stuff violating that stuff...because there's such hatred for people with mental illness in the community.... They suddenly start being nasty to you, and it's like: 'What did I do wrong?'

(Jenny – describing her concern about her safety in the ward where she perceived herself at risk from a male patient) Yeah, well they actually did believe me not because I came across as rushed but because I was very careful, even though I was in - I had a side effect...it was like a panic attack really bad, but it was a chemically induced panic attack type thing...and I was very careful to present myself in a way that was, like, calm and rational and not to seem like I was angry or upset or - I was too panicked to be upset, to be angry even. I was so scared.

(Interviewer) So you'd realised that you had to behave in a certain way in order for them to listen to you or to believe you?

(Jenny) Yes, because, when you've got the diagnosis, that just overtakes everything. You have no rights anymore, you can be discriminated against...I was terrified of this man next door because I thought, you know, like - he just seemed like scary to me and I was worried about being raped to be honest in the psych ward because I think if it happens, who's going to believe me, you know. Like, she [the nurse] was threatening; they were threatening to call the code black [emergency response usually involving seclusion and restraint] because I wouldn't take a drug, because I wanted to be awake at night in case he tried to come into my room.

We are also concerned that the MHA must reflect the diversity of the population, and that it may unintentionally reflect a limited cultural context. Diversity (such as CALD, Aboriginal and Torres Strait Islander, religious, LGBTQI, complex communication needs, etc) must be explicitly reflected. Otherwise, a narrow culture-bound view may prevail. This would be particularly relevant when considering the term 'understanding appropriate treatment'.

³ Lawn, S., Delany, T., Pulvirenti, M., McMillan, J. (2015) A qualitative study using moral framing to understand patients' and mental health workers' experiences of community treatment orders. BMC Psychiatry, 15, 274-290.

Section 5A – Decision making capacity

- (3) c. a person may fluctuate between having impaired decision-making capacity and full decision-making capacity. LEA is of the view that this point requires further consideration. A person with mental illness who is subject to the MHA may not have insight into their own mental health conditions, this may fluctuate, or it may vary according to condition and context. They may also not fully recognise the impacts that this may have on family/carers and the community. They may, in some circumstances, be unduly influenced by spurious claims, scams, or otherwise vulnerable to suggestions that are not in their interests, and which they otherwise would be alternative decisions about if they were in recovery. Any person may make decisions or choices that they would otherwise regret; however, the issues of suggestibility and manipulation are different concerns, particularly where impaired decisions-making capacity is apparent. They may be a risk to themselves or others but not grasp the relevancy to themselves. They may well understand health care, i.e., hospitalisation, where they reside, and some understanding of their personal affairs. There must always be vigilance in understanding decision-making capacity to ensure the concerns raised by others to distinguish between persuasion, offers, threats and coercion in care.⁴

Other than this, LEA is of the view that the current wording is sufficient.

2. How can the law better protect the human rights of persons with a lived experience of mental illness and provide supported decision-making?

LEA believes Part 2 – Objects and guiding principles cover sufficiently the human rights of persons experiencing mental illness.

We recognise the complexity of balancing various rights, such as those noted by the WHO regarding the right to health, and how these are interpreted and then used variously to justify how participation /involvement in decision-making is considered, or not. This particularly relates to the right to control one's health and body, the right to a system of health protection involving equal opportunity to attain health, and so forth.

Point (b) The MHA confers limited powers to psychiatrists in making orders. We believe this is adequate given the SACAT is an independent oversight and review body.

However, whilst the Objects and guiding principles are clear, putting these into practice by the mental health services does not always happen. Hence LEA queries whether there are any legal implications for the services which either deliberately or unwittingly breaches any of these principles. We acknowledge these are principles only and are a guide to best practice but would like to see more written into the MHA to enable persons or families/carers to have a complaints mechanism that is independent and can make decisions rather than just recommendations such as the SA Health and Community Services Complaints Commission.

There could be more explicit requirement for discussion with identified support people such as family, carers, kin, close friend who has been clearly identified by the person. However, we recognise that some people may not have an identified support person, services may not be aware of such a person, or have failed to find out. The person may also not want their family or carer involved, though we know from our research with consumers and carers that many people do want them involved, yet they are excluded from involvement and not consulted.⁵

We also believe that there is a role for mental health peer workers, who have sufficient training and experience, to play a more active role in supported decision making with the person. Legislation could enable them in this role as a non-legal advocate, for example.

⁴ Szmukler, G., Appelbaum, P. (2008) Treatment pressures, leverage, coercion and compulsion in mental health care. *J Ment Health*,17, 233–244.

⁵ Kaine, C. & Lawn, S. (2021) *The 'Missing Middle' Lived Experience Perspectives*. Lived Experience Australia Ltd: Marden, South Australia, Australia.

Inpatient Treatment Orders

1. Should the definition of 'treatment' be expanded to include an assessment or other medical/health issues?

Under sections 27, 28 and 29, treatment of patients to whom all three level orders apply notes that a patient under this order can be given treatment for mental illness, or *for any other illness that may be causing or contributing to the mental illness*. As such LEA does not consider the definition of 'treatment' should be expanded. This would see a rise in the use of ITO, and this certainly would infringe on people's human rights.

LEA believes the definition noted with the MHA, as above, is sufficient to cover any illnesses. These MUST relate specifically to mental illness and the person's decision-making capacities. Expanding the definition would allow more powers to detain and use force against a person. As such, LEA feels very strongly that the definition of treatment should remain as is within the MHA.

2. Should the MHA allow powers to detain and use force? If so, who should be allowed to detain and use force?

As above. There is concern about how 'reasonable and necessary' is operationalised within practice by mental health professionals and by police and ambulance personnel. Hence, there is room for improving clarity and consistency in these terms.

Community Treatment Order

1. Should the law and practice be re-framed to limit or reduce the number of CTOs? Why or why not?

LEA considers that consideration should be given to re-framing practice in relation to CTOs. We acknowledge that many people, because of their mental illness, may require a CTO. However, we also note that Australia has one of the world's highest rate of CTOs, as high as 112.5 per 100,000 people,⁶ with considerable variation in the use of these controversial orders across and within jurisdictions. There is emerging evidence that forced community treatment is applied arbitrarily and disproportionately effects marginalised groups such as Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse (CALD) backgrounds. Organisational factors related to how the MHA is operationalised within different jurisdictions appears to be influencing this variation. There is an urgent need to understand why this variation occurs to ensure the human rights of people with mental health conditions are realised.⁷

We acknowledge that many people respond well to psychiatric medication, though LEA also acknowledges that this comes with disadvantages such as physical health issues, weight gain, tiredness, lack of motivation etc. However, when a person is relied upon to continue to take the medications, they sometimes feel better so stop doing so. This can have disastrous consequences to the person, and those around them. The mental health services understand and acknowledge when someone is psychotic, or delusional yet fully believe them when they say they will continue to take their medication, voluntarily. Despite the intervention of families/carers, the mental health services often choose the 'least restrictive' option. However, we know that severe consequences can result, such as physical violence, loss of employment, relationships and supports, housing tenure, finances and so forth. This can particularly impact the person's recovery path and progress. These potential adverse impacts of not having a CTO in place where it is clearly of value in ensuring effective treatment and care, must be taken into consideration, and it is LEA's view that such provisions of CTOs under the current MHA should remain.

Cultural change within mental health services with regard to improved listening, involvement in decisions about care, involvement in care planning and so forth is what is needed.⁸

6 Light, E. (2019). Rates of use of community treatment orders in Australia. *Int J Law Psychiatry*, 64, 83-87.

7 Brophy, L., Edan, V., Gooding, P., McSherry, B., Burkett, T., Carey, S., Carroll, A., Callaghan, S., Finch, A., Hansford, M., Hanson, S., Kisely, S., Lawn, S., Light, E., Maher, S., Patel, G., Ryan, C.J., Saltmarsh, K., Stratford, A., Tellez, J.J., Toko, M. and Weller, P. (2018). Community treatment orders: Towards a new research agenda. *Australas Psychiatry*, 26(3):299-302.

8 Dawson S, Muir-Cochrane, E, Simpson, A, Lawn S. (2021). Risk versus recovery: care planning with individuals on community treatment orders. *Int J Ment Health Nurs*, 30(5), 1248-1262.

2. *Should the MHA be changed to include a power to use reasonable force in cases involving noncompliance with a CTO?*

LEA does not condone the use of any force, reasonable or otherwise. Mental health clinicians are trained in the use of de-escalation techniques; however, it is often the case currently that security is brought into mental health units as the first response when a person expresses that they do not want to take medication. Again, we believe that in many instances, issues that arise are more about the culture of service provision and mental health professionals' behaviours towards the person that lead the person to refuse treatment. Such situation can include actual or perceived pressures to enforce medication taking due to administrative convenience and schedules, and absence of time spent helping the person to understand why medication is useful or needed. Failure to collaborate with families to help support the person to understand treatment and follow-through consistently can also occur.

People react when a negative response is given to them, just as with any other person. However, their mental health status often brings additional burdens. These can be interpreting language, directions etc. It is therefore in LEA's views, that very few instances require reasonable force. We stress that there is much more focus needed within the system of care long before the potential need to use force or to enact de-escalation techniques. We do, however, absolutely acknowledge the need if life is at risk, and suitable force should be taken to ensure the safety of everyone.

Restrictive Practice and Control Powers

1. *Should the MHA allow use of reasonable force and control powers? If so, when?*

LEA does consider that, in a very small number of instances, the use of reasonable force or control powers is appropriate. However, we believe this should be confined to the community environment where people can be an imminent risk to themselves or others.

What LEA has great difficulty with is when force and control is used where mental health clinicians are employed, i.e., mental health inpatient unit, community mental health settings. It would be considered that escalation of concerning behaviours should be dealt with by the mental health clinicians, who should be well trained in de-escalation techniques, knowledge, and skills. Force and control via seclusion, mechanical, or physical means must be eliminated.

LEA does have a view that in a small number of instances in the Emergency Room environment, for example, chemical, physical or even mechanical restraint may be considered appropriate, used only in order to keep the clinicians, public and the person themselves free from harm. These powers should only be used as a last resort.

2. *Who should be allowed to use force and exercise control powers?*

Further, we are seeing security guards being used more frequently in all mental health, ED, and other health settings. We believe that these personnel should only be engaged to the extent to keep the public safe. We are seeing mental health clinicians on inpatient units calling for security when they seem unable or unwilling to engage with someone who they deem to be a danger to them. LEA believes this is most inappropriate given their knowledge of people's behaviour when affected by mental health issues. The use of these guards adds to the stigma of mental health issues and should reasonably be eliminated.

3. *What is 'reasonable' and how should this be defined?*

As above, our concern is that determination of the term 'reasonable' is solely in the eyes of the person undertaking these controls and powers and is therefore open to being mis-used and biasing the health professional who may or may not have sufficient skills or information to fully judge the situation or needs of the person before them. Only authorised personnel with adequate training should ever be engaged within these areas and only as a matter of last resort, for the shortest possible time. It should be overseen/authorised by a mental health clinician, preferably one who knows the person, has empathy and respect for the person and high-level skills.

Electroconvulsive Therapy

1. Should the law allow reasonable force to ensure a person receives ECT? If so, when?

Absolutely not. Force for ECT is never appropriate. ECT is not given to save a life such as a transfusion, emergency surgery, cardiac arrest etc. There is adequate lead in time for a person to be informed about the use of ECT, why it is considered appropriate for their circumstances, and what the side effects will be. People mostly given ECT, as noted within Fact Sheet 6, are those with bipolar or major depression. LEA considers that even people with these mental health diagnoses can provide informed consent by understanding the implications of the treatment, positive and negative. Again, time should be given to each and every person to enable them to make an informed choice about ECT, in an effort to avoid the perceived need for the use of force.

2. How can the rights of a consumer be better protected in cases of emergency ECT?

As mentioned, we do not believe there is 'emergency' ECT where immediate decisions are made.

However, if emergency ECT is considered within the MHA, then people and/or their families and carers MUST be provided with sufficient time and information to make the informed decision, receive a copy of their rights to refuse, seek a second opinion, etc and these processes must be written into the MHA.

3. Should the PPTP provide more or less oversight of ECT (including maintenance ECT) and/or other treatments?

When medical procedures are given to any individual without their informed consent, the role and function of the Prescribed Psychiatric Treatment Panel ('PPTP') must remain as an independent oversight body to ensure people's rights are upheld. Further, LEA considers further functions should be added to the role of the PPTP, adequate funding provided to ensure this body acts as it should.

LEA believes that under MHA the provision of ECT should always been closely monitored.

SACAT and Legal Representation

1. Should the MHA be amended to entitle consumers to legal representation under the scheme in cases where SACAT reviews its own decision?

LEA is of the view that all people with lived experience are provided with free legal representation when their case comes before SACAT. Whilst this is applicable under the MHA, it does not relate often in practice. We know of people who come before SACAT with no legal representation.

The consultation question relates to circumstances where SACAT reviews its own decision, and LEA is of the same view; people must be provided with free legal representation.

LEA is aware of cases where the person, their mental health team (psychiatrist) and their family want 12-month renewal of CTOs, for example, where SACAT determines that 6 months is appropriate. These decisions do not represent the clinical view, or those of the person or their family.

2. Should the MHA legal representation scheme be extended to provide representation to families and carers who apply for review of treatment orders?

Families and carers know to a large degree how the person is travelling, their hopes, challenges etc and yet have limited options to input into decisions of SACAT, especially when they do not agree with the decisions.

LEA believes that carers/families are also entitled to free legal representation when hearings are brought for the person they are supporting. This will support their knowledge of the person, their vulnerabilities, choices, other issues caused by their mental ill-health, particularly when the person may have limited or no insight at that stage in their illness.

We also note that family carers may include young carers, or family with particular needs of their own. Hence, support that takes their needs into account, should be a consideration re legal representation.

The Role of the South Australia Police

1. Should SAPOL be involved in the enforcement of the MHA? If not, who should be given these powers?

SAPOL should only be involved in enforcing the MHA when required and only in the community environment, to keep the person or others safe from harm. This does relate to transportation of the person to hospital, and if the person has left the hospital without permission. LEA does not believe SAPOL should be involved if a person does not comply with a CTO. We believe this is the responsibility of mental health teams. A case could be made that if a person has a history of aggression, a mental health clinician should accompany SAPOL in all situations involving people with mental health issues.

2. Should the law allow hospital staff to use reasonable force to 'hold' a person until SAPOL arrives?

There are risks to staff performing this role (physical and psychological), to the person (physical and psychological, trauma), and to the relationship, trust and future potential help-seeking, where the people tasked with providing care and also using coercion to provide that care. There is also concern for the distress that witnessing coercion can have for other patients, family members (eg. children) or others in the immediate environment in which force is implemented. Every effort should be used to avoid staff needing to resort to use of force.

SAPOL should never be engaged within mental health services other than to transport people there. The core business of mental health inpatient units is to provide treatment and care to address the acute mental health needs of the person, and to keep people with mental illness safe from harm to themselves and/or others. They have the knowledge, skills, mandate etc to use these things to protect a person, rather than force to hold a person.

The only instance we can think of is if someone is transported from prison, but where would a person be transferred to, if held by the mental health services? The only area we can think of is forensic mental health care i.e., James Nash House; in that case, LEA sees this as being appropriate.

3. Should the law allow the use of care and control powers to enforce cross border arrangements?

LEA is of the view that communication and integration of mental health legislation should be a national issue and consistent across borders. This should also include more transparent reporting and accountability at a national level.

Guiding Principles and Accountability Mechanisms

1. How can these guiding principles be enforced into practice?

LEA notes reference to Victoria's new Mental Health and Wellbeing Act. LEA made a Submission to the Victorian Department of Health in July 2021 expressing our perspectives, experiences, and views.

Our view is the same with the review of SA's MHA and question how cultural change which we know is a major issue and urgently needed, can support reduction in restrictive practices and compulsory treatments and how these can be achieved as a goal, within a legal framework.

We believe that more must be done to ensure care plans for people who are subject to the MHA, and anyone using mental health services, are developed with greater involvement and collaboration with the person, and their family / carers (if present and with the person's consent). Too often, care plans reflect service-driven clinical compliance goals and fail to include what is important and meaningful to the person in the whole life and needs. Little wonder that many people do not engage with treatment that serves only to disempower the person; or silences their input.

2. If applied or not in practice, do these guiding principles impact access to services?

How can the MHA profoundly change attitudes that are entrenched? Stronger, and clearer accountability mechanisms must be introduced either as an adjunct to the MHA as they are proposing in Victoria

preferably; or strengthened under the MHA. If the principles of the MHA were consistently implemented, it is our opinion that there would be less need to enforce the MHA. These are stated below, but in practice, many are questionable currently.

- Lead to the best treatment outcome, promoting recovery.
- Meet the highest standard of quality and safety.
- Ensure the least restrictive practices are used; and
- Consider the age of a person, gender, sexuality, disability, culture, language, and past trauma

3. How might the MHA provisions be changed to improve the consumer's access to service?

Access has been and remains a real issue in South Australia. People are being discharged before they should be, and there is a constant debate about whether someone on an inpatient unit is less acute than someone presenting to the emergency department. This bed pressure does not make for a safe environment and pushes clinicians to make decisions they would not wish to make. The system currently is broken, siloed, un-coordinated, and lacks integration. LEA does not see how the various elements of the MHA can change this situation.

However, the MHA is set up as a legal entity to protect the rights of people with a lived experience and must remain, strengthened, and easily implemented. Having said this, if the culture of the mental health system was as it should be, then aspects of the MHA would not be required. Rather, de-escalation training, removal of security guards, etc would certainly enhance the environment in which safe and effective mental health care and treatment can and should be provided, for the amount of time required.

4. What, if any, measures for accountability and monitoring should be included in the MHA?

We support the expansion and statutory provisions of the current Mental Health Commission – see Other Issues point three below.

Other Issues

1. How can the CVS be improved to enhance access to Community Visitors and its efficiency?

The CVS is a body that is needed to monitor safety and quality and protect the rights of people under the act, those within inpatient settings, etc.

However, LEA believes the powers of the CVS should be expanded to incorporate the current expanded diversity of community mental health settings and the private hospital sector. This needs to be articulated under the MHA, with their powers clearly noted.

2. Should the director of an authorised community mental health facility inform the CVS of a request within 2 days?

LEA believes this is consistent with good practice and we would recommend this occur.

3. Should the role of a Mental Health Commissioner be clearly defined under the MHA?

There is a real need for an independent accountability entity that can ensure the rights of people are protected. In the Victorian legislation, it is proposed to have a Mental Health and Wellbeing Commission as the oversight body. We have this in SA, but it was not implemented as a statutory body. This needs to be done as a matter of urgency. The independence of the Mental Health Commissioner role is paramount if the community is to trust the integrity of the role; they cannot simply be there to reinforce the views of the bureaucracy of the politics of the day.

Consideration could be given to strengthening the Health and Community Services Complaints Commission's role to undertake this work. Currently the Commission can conduct investigations but only make recommendations with no powers to enforce them.

Contact

We thank the SA Law Reform Institute for the work that has gone into the Fact Sheets and this review process. I would be keen to discuss further, any clarification or issues raised with you.

Please contact me on:

Professor Sharon Lawn

A handwritten signature in black ink that reads "Sharon". The signature is written in a cursive, flowing style.

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